

FFM

Application Process

Application Process

Online

Quick
◆
Dynamic application that gathers all necessary information
◆
Complete process at one time

Must create an online account
◆
Must pass ID Proofing before moving forward

Paper

Can complete several in a single event
◆
Can send copies of ID information with application

Delays
◆
Must wait for FFM to enter
◆
Questions may not be answered completely
◆
Will involve follow up

Call Center

◆
Quick
◆
All info is entered
◆
Complete process at one time

Cannot see the screen when they are reviewing available plans
◆
Wait times during OEP

FFM Application Process

Apply online at HealthCare.gov

- Create a HealthCare.gov account
User name and password
- ID Proofing
Verifies Identity
- Complete Application electronically
- Receive Eligibility Determination
Alerted if there is a Data Matching Issue (DMI)
- Enroll in a plan
- 90-95 Days to resolve DMI by uploading or mailing documents

Application Process

Apply by calling the Health Insurance Marketplace

Call Center number 800-318-2596 (24/7)

- Assistants can call with the individual to assist in application process. Verbal Authorization will be required.
- Interpretation Services Available
- **Do not need to create a healthcare.gov account to apply and enroll**

Application Process

Apply with paper application

- **Enter all information into the paper application**
Include copies of any documents
- **Mail application**
- **Healthcare.gov receives and enters information**
May contact consumer if more information is needed
- **Consumer will be mailed an eligibility determination within 2 weeks**
Eligibility determination may include any Data Matching Issues (DMI) that need resolved.
- **Create an online account or use the Marketplace Call Center to enroll.**

Application Process

Application ID

- Each Marketplace application has a unique identification number, or Application ID. Notices and correspondence from Health Insurance Marketplace will contain Application ID.
- Consumers will need their Application ID to continue with an existing online application, compare plans, and complete enrollment.
- Consumers can provide their Application ID to the Marketplace Call Center representative when calling for application look up.
- When continuing an application, comparing plans, and enrolling online, consumers will be asked to enter their Application ID after they have logged into their account and select "Find my existing application."

Application Process



Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

May Leon
[insert address]

[date]

Application Date: [date]

Application ID: 129990294

Important: Your **Eligibility Results** for Health Insurance Marketplace coverage

Online Application

Application Process

The screenshot displays the HealthCare.gov website interface. At the top, the 'HealthCare.gov' logo is on the left, and navigation links for 'Individuals & Families', 'Small Businesses', 'Español', and 'Log in' are on the right. The 'Log in' link is highlighted with a red rectangle. Below the navigation bar, a secondary menu includes 'Get Coverage', 'Change or Update Your Plan', 'Get Answers', 'See Topics', a search bar, and a 'SEARCH' button. The main content area features a large banner with the text 'Open Enrollment starts soon. Are you ready?' and a photo of a diverse group of people. Below the banner, two green buttons are visible: 'GET READY TO APPLY' for first-time users and 'GET READY TO KEEP/CHANGE' for those with existing plans. A link for Kentucky-specific information is also present. Further down, four dark blue boxes with icons and text provide quick links: 'STILL NEED '16 PLAN?' (with a pencil icon), 'WILL YOU SAVE?' (with a dollar sign icon), 'UNDER 30?' (with a person icon), and 'DATES & DEADLINES' (with a calendar icon). Each box contains a corresponding button: 'SEE IF YOU CAN ENROLL', 'FIND OUT FAST', 'GET A CUSTOM GUIDE', and 'SEE NOW'. At the bottom, two more links are shown: 'GET IMPORTANT NEWS & UPDATES' and 'HEALTHCARE.GOV BLOG'.

HealthCare.gov

Individuals & Families

Small Businesses

Español

Log in

Get Coverage

Change or Update Your Plan

Get Answers

See Topics

Search

SEARCH

Open Enrollment starts soon.
Are you ready?

First time applying here?

GET READY TO APPLY

Have a 2016 Marketplace plan?

GET READY TO KEEP/CHANGE

Have a 2016 plan in Kentucky? [Learn about using HealthCare.gov for 2017.](#)

STILL NEED '16 PLAN?

WILL YOU SAVE?

UNDER 30?

DATES & DEADLINES

SEE IF YOU CAN ENROLL

FIND OUT FAST

GET A CUSTOM GUIDE

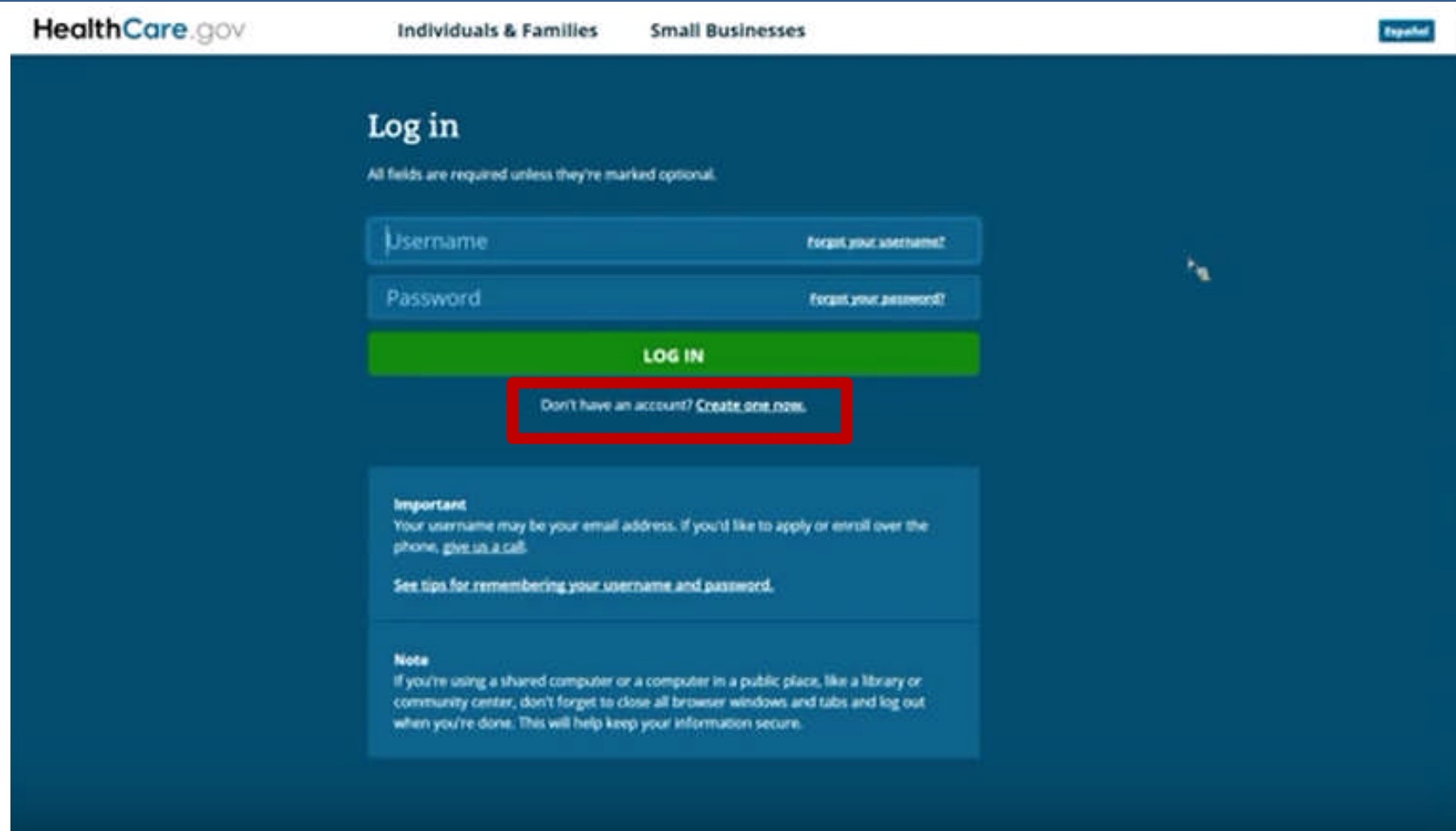
SEE NOW

GET IMPORTANT NEWS & UPDATES

HEALTHCARE.GOV BLOG

KHBE
Kentucky Health Benefit Exchange

Application Process



The screenshot shows the HealthCare.gov login interface. At the top, the 'HealthCare.gov' logo is on the left, and 'Individuals & Families' and 'Small Businesses' are in the center. A 'Español' link is on the right. The main heading is 'Log in', followed by the note 'All fields are required unless they're marked optional.' Below this are two input fields: 'Username' and 'Password', each with a 'Forgot your [username/password]?' link. A green 'LOG IN' button is centered below the fields. A red rectangle highlights the link 'Don't have an account? Create one now.' Below the login section, there are two informational boxes: 'Important' (stating that the username can be an email address and providing a phone number for assistance) and 'Note' (warning about security on shared computers).

HealthCare.gov Individuals & Families Small Businesses Español

Log in

All fields are required unless they're marked optional.

Username [Forgot your username?](#)

Password [Forgot your password?](#)

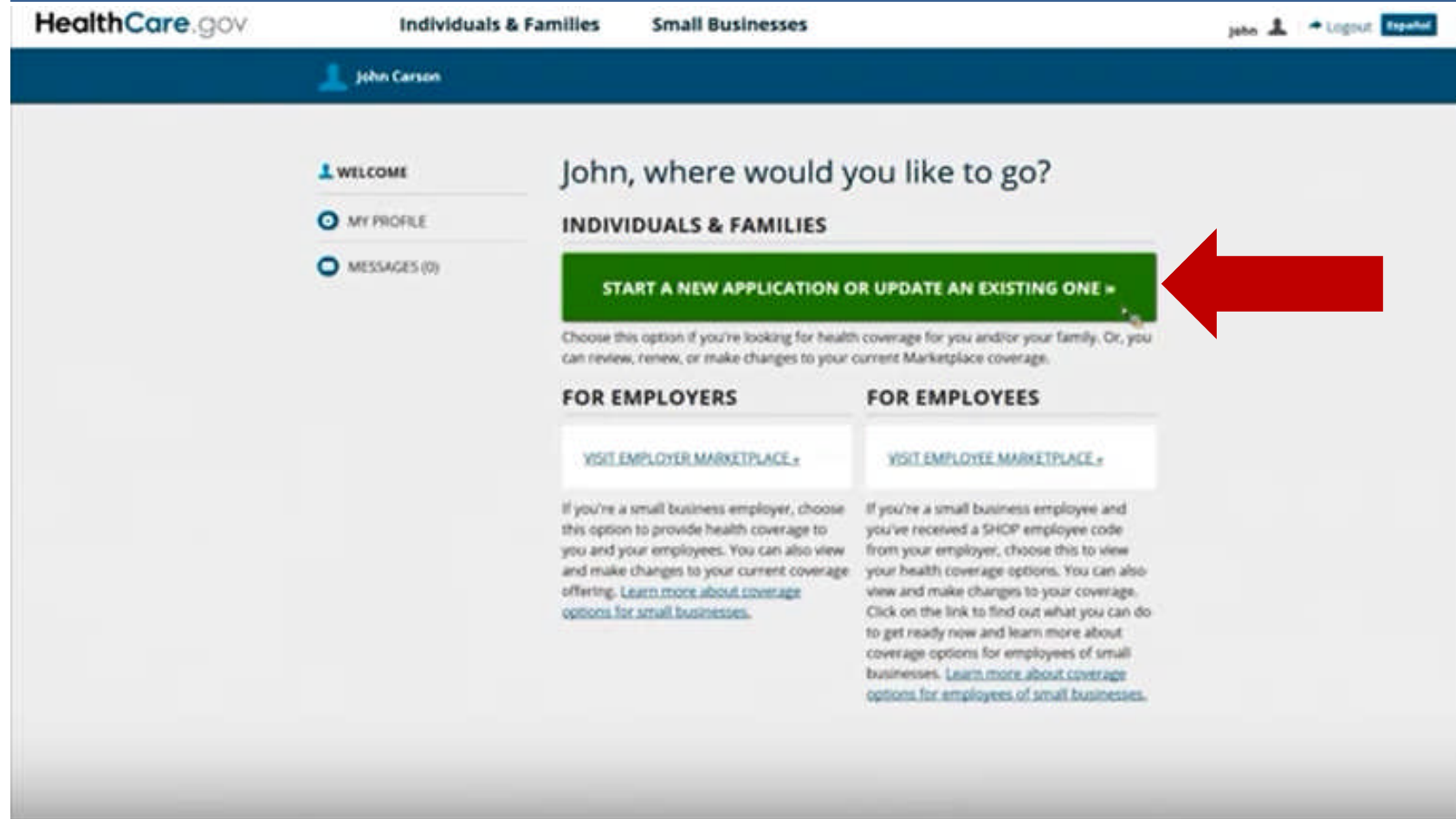
LOG IN

Don't have an account? [Create one now.](#)

Important
Your username may be your email address. If you'd like to apply or enroll over the phone, [give us a call](#).
[See tips for remembering your username and password.](#)

Note
If you're using a shared computer or a computer in a public place, like a library or community center, don't forget to close all browser windows and tabs and log out when you're done. This will help keep your information secure.

Application Process



Application Process

The screenshot shows the HealthCare.gov website interface. At the top, the logo "HealthCare.gov" is on the left, and navigation links for "Individuals & Families" and "Small Businesses" are in the center. On the right, there is a user profile for "john" with a "Logout" button and a "Español" link. Below the navigation bar, a dark blue header displays the user's name "John Carson" next to a person icon. The main content area has a dark blue background with the heading "You've almost finished your 2016 application". Below this, a message states: "You've started an application, but you need to take a few more steps to get coverage for 2016:". A numbered list follows: "1. Finish and submit your application.", "2. View your 'Eligibility Results.'", and "3. Choose and enroll in a plan by **December 15**, so your coverage can start on January 1." A prominent green button labeled "FINISH MY APPLICATION" is centered below the list. Further down, a light blue box contains the heading "Need coverage for 2015?", the instruction "Select 'Get 2015 Coverage,' then select 2015 and your state from the drop-down list.", and a blue button labeled "GET 2015 COVERAGE". The footer is a light gray bar with links for "SITE MAP", "GLOSSARY", "CONTACT US", "ARCHIVE", "ACCESSIBILITY", "PRIVACY POLICY", "LINKS TO OTHER SITES", "PLAIN WRITING", and "VISITORS & PLAYERS".

HealthCare.gov Individuals & Families Small Businesses john Logout Español

John Carson

You've almost finished your 2016 application

You've started an application, but you need to take a few more steps to get coverage for 2016:

1. Finish and submit your application.
2. View your "Eligibility Results."
3. Choose and enroll in a plan by **December 15**, so your coverage can start on January 1.

FINISH MY APPLICATION

Need coverage for 2015?

Select "Get 2015 Coverage," then select 2015 and your state from the drop-down list.

GET 2015 COVERAGE

[SITE MAP](#) | [GLOSSARY](#) | [CONTACT US](#) | [ARCHIVE](#) | [ACCESSIBILITY](#) | [PRIVACY POLICY](#) | [LINKS TO OTHER SITES](#) | [PLAIN WRITING](#) | [VISITORS & PLAYERS](#)

Application Process

The screenshot shows the HealthCare.gov website interface. At the top, the logo 'HealthCare.gov' is on the left, and navigation links for 'Individuals & Families' and 'Small Businesses' are in the center. On the right, there are links for 'john', 'Logout', and 'Español'. Below the navigation bar, a user profile for 'John Carson' is displayed. The main heading is 'Need coverage for 2016?'. Underneath, it lists requirements: 'You'll need to: 1. Complete a 2016 application. 2. View your "Eligibility Results."'. A red rectangle highlights a 'Select State' dropdown menu and a 'START MY APPLICATION' button. Below this, there is a section titled 'Want to learn more before you get started?' with a button 'FIND OUT WHAT THINGS YOU'LL NEED TO APPLY'. At the bottom, there is a section titled 'Need coverage for 2015?' with instructions to 'Select "Get 2015 Coverage," then select 2015 and your state from the drop-down list.' and a button 'GET 2015 COVERAGE'.

HealthCare.gov Individuals & Families Small Businesses john Logout Español

John Carson

Need coverage for 2016?

You'll need to:

1. Complete a 2016 application.
2. View your "Eligibility Results."

Select State

START MY APPLICATION

Want to learn more before you get started?

FIND OUT WHAT THINGS YOU'LL NEED TO APPLY

Need coverage for 2015?

Select "Get 2015 Coverage," then select 2015 and your state from the drop-down list.

GET 2015 COVERAGE

Application Process

The screenshot shows the HealthCare.gov website with the 'Individuals & Families' tab selected. The top navigation bar includes 'HealthCare.gov', 'Individuals & Families', 'Small Businesses', and a user profile with a 'Log out' link. Below the navigation bar, a progress bar shows 'Apply' as the current step, followed by 'Get Results' and 'Get Coverage'. The main content area is titled 'Your identity has been verified' and includes the following sections:

- Your identity has been verified**
You can now fill out your application for health coverage through the Marketplace.
- Important Marketplace emails**
If the Marketplace has your email address, we'll automatically send you important information, updates, and reminders about Marketplace enrollment. You can opt out of these communications at any time. To do this, click on the "unsubscribe" link in the footer of any Marketplace email.
- Privacy & the use of your information**
We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health coverage or help paying for coverage. We'll check your answers using the information in our databases and the databases of other federal agencies. If the information doesn't match, we may ask you to send us proof. We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

As part of the application process, we may need to retrieve your information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security (DHS), and/or a consumer reporting agency. We need this information to check your eligibility for coverage and help paying for coverage if you want it and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.

[Learn more about your data](#), or view the [Privacy Act Statement](#).

At the bottom, there is a checkbox labeled 'I agree to have my information used and retrieved from data sources for this application. I have consent for all people I'll list on the application for their information to be retrieved and used from data sources.' A large red arrow points to this checkbox.

Application Process

The screenshot shows the HealthCare.gov website interface for the application process. At the top, the 'HealthCare.gov' logo is on the left, and 'Individuals & Families' and 'Small Businesses' are in the center. On the right, there is a user profile 'john' and a 'Log out' link. Below the navigation bar, a blue banner contains three buttons: 'Apply' (highlighted), 'See Results', and 'See Coverage'. The main content area is titled 'Before you get started' and includes instructions to fill in household information. The first question is 'Are you single or married?' with two radio button options: 'SINGLE' and 'MARRIED'. The 'MARRIED' option is selected. The second question is 'How many tax dependents, like your children, will you claim on your 2016 tax return?' with a dropdown menu currently set to 'Select...'. A large green 'CONTINUE' button is positioned below the questions. The footer contains links for 'About Us', 'Help', 'Contact Us', and 'Privacy', along with logos for the U.S. Department of Health and Human Services and USA.gov.

HealthCare.gov Individuals & Families Small Businesses john Log out

Apply See Results See Coverage

Before you get started

Fill in the information below about your household. Not applying for coverage in Mississippi? [Change your state.](#)

Are you single or married?

☐ SINGLE ☒ MARRIED

How many tax dependents, like your children, will you claim on your 2016 tax return?

Include all of your dependents on your 2016 tax return, even those not applying for coverage.
Don't include yourself or your spouse.

Select...

CONTINUE

[About Us](#) | [Help](#) | [Contact Us](#) | [Privacy](#)

[Accessibility](#) | [Privacy](#) | [Terms of Use](#) | [Your Health](#) | [Resources & Plans](#)

a federal government website managed by the
U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Application Process

Before you get started

Fill in the information below about your household. Not applying for coverage in Mississippi? [Change your state.](#)

Are you single or married? ⓘ

☐ SINGLE

☒ MARRIED

How many tax dependents, like your children, will you claim on your 2016 tax return? ⓘ

Include all of your dependents on your 2016 tax return, even those not applying for coverage.
Don't include yourself or your spouse.

Of the 3 people above, who are you applying for coverage for? Select all that apply. ⓘ

☒ ME

☐ MY SPOUSE

☐ MY DEPENDENT


How much income will your household make this year? (optional) ⓘ

☐ \$84,000 OR LESS

☐ MORE THAN \$84,000

Do you want to answer additional questions to see if you qualify for help paying for coverage? ⓘ



Application Process

want to answer additional questions to see if you qualify for help paying for coverage? 


☒ YES ☐ NO


CONTINUE

Questions about you, your spouse, and 1 dependent

☒ YES ☐ NO Does everyone have the same permanent home address AND currently live in Mississippi?  

☒ YES ☐ NO Do you plan to file a joint federal income tax return with your spouse for 2016?


You don't have to file taxes to apply for coverage, but you'll need to file next year if you want to get a premium tax credit to help pay for coverage now. 

☐ YES ☒ NO Are you and your spouse responsible for a child 18 or younger who lives with you, but isn't on your tax return? 

☐ YES ☒ NO Is anyone a full-time student aged 18-22?

☐ YES ☒ NO Is anyone pregnant, or has anyone had a child in the last 60 days?

**Questions about people applying for coverage:
You, your spouse, and 1 dependent**

☐ YES ☒ NO Are all of you U.S. citizens? 

Application Process

YES NO Are you and your spouse responsible for a child, or a young person who lives with you, who isn't on your health insurance?

YES NO Is anyone a full-time student aged 18-22?

YES NO Is anyone pregnant, or has anyone had a child in the last 60 days?

Questions about people applying for coverage: You, your spouse, and 1 dependent

YES NO Are all of you U.S. citizens? ⓘ

YES NO Can you enter Social Security Numbers (SSNs) for each of you? ⓘ

YES NO Are any of you applying under a name different than the one on your Social Security card? ⓘ

YES NO Are any of you naturalized or derived citizens? (This usually means a U.S. citizen who was born outside the U.S.) ⓘ

YES NO Are any of you currently incarcerated (detained or jailed)?

YES NO Are any of you an American Indian or Alaska Native? ⓘ

YES NO Are any of you offered health coverage through your job, someone else's job, or COBRA? (Select "Yes" even if any of you didn't enroll, or the enrollment period is over.) ⓘ

YES NO Were any of you in foster care at 18 AND are currently 25 or younger?

Application Process

- YES** **NO** Can you enter Social Security Numbers (SSNs) for each of you? ⓘ
- YES** **NO** Are any of you applying under a name different than the one on your Social Security card? ⓘ
- YES** **NO** Are any of you naturalized or derived citizens? (This usually means a U.S. citizen who was born outside the U.S.) ⓘ
- YES** **NO** Are any of you currently incarcerated (detained or jailed)?
- YES** **NO** Are any of you an American Indian or Alaska Native? ⓘ
- YES** **NO** Are any of you offered health coverage through your job, someone else's job, or COBRA? (Select "Yes" even if any of you didn't enroll, or the enrollment period is over.) ⓘ
- YES** **NO** Were any of you in foster care at 18 AND are currently 25 or younger?

Questions about your 1 dependent

- YES** **NO** Will you claim your dependent on your federal income tax return for 2016?
- YES** **NO** Is this your child who is single (not married) and 25 or younger?
- YES** **NO** Is this your stepchild or grandchild?
- YES** **NO** Do they live with a parent who's not on your tax return?

CONTINUE

Application Process

Continue your application

After you complete this section, you'll answer a few more questions before you compare plans.

Household contact information

These fields are optional: middle name, suffix, and preferred written and spoken languages.

John	Middle	Carson	Suffix *
Email address		Phone number	
jcarsonstest5@yahoo.com		601-555-1234	
Preferred written language		Preferred spoken language	
English		English	

☐ Go paperless! Get your notices by email instead of paper copies in your mailbox.

☐ Another person is helping me complete my application. ⓘ

Home address

Enter the permanent address where everyone on your application lives. The apt./ste. # field is optional.

824 Deborah St.			Apt./Ste. #
Jackson	Mississippi	39208	RAHON

YES **NO** Is your mailing address the same as your permanent address?

Check & update your information

Application Process

YES **NO** Is your mailing address the same as your permanent address?

Check & update your information

If the name on your Social Security card is different than the name below, update it here so it's the same as it appears on your Social Security card. These fields are optional: middle name, suffix, and race & ethnicity.

John	Middle	Carson	Suffix *
Date of birth 06/19/1961	Social Security Number (SSN) 317-20-1506	Male	Race & ethnicity *
Check all that apply. These fields are optional			
<input type="checkbox"/> Hispanic, Latino, or Spanish origin	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Black / African American	<input type="checkbox"/> Chinese
<input type="checkbox"/> American Indian / Alaska Native	<input checked="" type="checkbox"/> Guamanian / Chamorro	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean
<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Samoan
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> White	<input type="checkbox"/> Other	
<input type="checkbox"/> Vietnamese			

Optional

YES **NO** Are you applying for coverage for yourself?

Spouse information

These fields are optional: middle name, suffix, and race & ethnicity.

First name	Middle	Last name	Suffix *
Date of birth MM/DD/YYYY	Social Security Number (SSN) XXX-XX-XXXX	Sex	Race & ethnicity *

YES **NO** Are you applying for coverage for this person?

Application Process

The screenshot displays the KHBE application interface. On the left, a sidebar lists steps: 'GET STARTED' (completed), 'FAMILY & HOUSEHOLD', and 'John Carson'. The main area shows 'John Carson's Information' with a blurred form. A modal dialog titled 'Are you sure?' is centered, explaining the importance of Social Security Numbers (SSNs) for everyone on the application. It states that entering SSNs makes the process smoother and faster by allowing automatic verification. The dialog includes two buttons at the bottom: 'CONTINUE WITHOUT SSN' and 'BACK'.

Application ID: 123456789

GET STARTED

FAMILY & HOUSEHOLD

John Carson

John Carson's Information

Are you sure?

It's important to enter the Social Security Numbers (SSNs) for everyone on your application, if they have them. Entering SSNs makes the application process go smoother and faster by allowing the Marketplace to check your information automatically. If you don't enter SSNs for people who have them, you may need to provide more information later.

CONTINUE WITHOUT SSN

BACK

Application Process

The screenshot displays the HealthCare.gov application interface. At the top, the 'HealthCare.gov' logo is on the left, and navigation links for 'Individuals & Families' and 'Small Businesses' are in the center. On the right, a user profile for 'john' is shown with a 'Log out' link. Below the navigation bar, a progress bar indicates the steps: 'Apply' (active), 'Get Financials', and 'Get Coverage'. The main section is titled 'Income information' with an 'Application ID: 129609646' on the right. A sub-header explains that income information is needed to determine eligibility for financial help, with a link to 'Learn more:'. Below this, a grid lists various income sources: Job, Social Security, Alimony, Scholarship, Self-employment, Capital gains, Farming or fishing, Other income, Unemployment, Investment, Rental or royalty, Pension, Retirement, and Cash support. The section 'Current income for John Carson' follows, with a prompt to 'Tell us about any income John had in the last month.' and a green button labeled 'ADD NEW SOURCE OF INCOME'. A large red arrow points to this button. Below the button, there is a question about the number of hours worked per week in the last month, followed by a text input field. At the bottom, there is a question about deductions for 2016, with radio button options for 'Yes' and 'No'.

HealthCare.gov Individuals & Families Small Businesses john Log out

Apply Get Financials Get Coverage

Application ID: 129609646

Income information

People can get income in many ways. We need to know about your income so we can figure out if you can get help paying for coverage. [Learn more:](#)

Job	Self-employment	Unemployment	Pension
Social Security	Capital gains	Investment	Retirement
Alimony	Farming or fishing	Rental or royalty	Cash support
Scholarship	Other income		

Current income for John Carson

Tell us about any income John had in the last month. ?

ADD NEW SOURCE OF INCOME

On average, how many hours per week did John work in the last month? ?

Does John have any deductions for 2016?

Application Process

Income Information

People can get income in many ways. We need to know about your income so we can figure out if you can get help paying for coverage. [Learn more.](#)

Job
Social Security
Alimony
Scholarship

Self-employment
Capital gains
Farming or fishing
Other income

Unemployment
Investment
Rental or royalty

Pension
Retirement
Cash support

Current income for John Carson

Tell us about any income John had in the last month. [?](#)

Select an income type

Type	\$ Amount	How often
Type		
Job		
Self-employment		
Unemployment		
Pension		
Social Security		
Capital gains		
Investment		
Retirement		
Alimony		
Farming or fishing		
Rental or royalty		
Cash support		
Scholarship		
Other income		

or John Carson

Based on what you entered, John's income minus any deductions for 2016 will be about \$0.00. Is this correct? [?](#)

YES No

Application Process

Whose income to include:

For most people, a household consists of the tax filer, their spouse if they have one, and their tax dependents, **including those who don't need coverage.**

The Marketplace counts estimated income of all household members who are required to file a tax return.

What income is counted

The Marketplace uses modified adjusted gross income (MAGI) to determine eligibility for savings.

MAGI is the total of the following for each member of a household who's required to file a tax return:

- adjusted gross income (AGI) on your federal tax return
- Excluded foreign income
- Nontaxable Social Security benefits (including tier 1 railroad retirement benefits)
- Tax-exempt interest
- MAGI **does not** include Supplemental Security Income (SSI)

Application Process

Current income for John Carson

Tell us about any income John had in the last month. ⓘ

Type

How much

Job / Local Grocery (601-555-4321)

\$16,000.00 per year

Edit Remove

ADD NEW SOURCE OF INCOME

On average, how many hours per week did John work in the last month? ⓘ

40

Does John have any deductions for 2016?

YES

NO

Yearly income for John Carson

Based on what you entered, John's income minus any deductions for 2016 will be about **\$16,000.00**. Is this correct? ⓘ

YES

NO

Estimates Annual
Income

Current income for Suzanne Carson

Tell us about any income Suzanne had in the last month. ⓘ

ADD NEW SOURCE OF INCOME

On average, how many hours per week did Suzanne work in the last month? ⓘ

Application Process

Current income for Suzanne Carson

Tell us about any income Suzanne had in the last month. ⓘ

Type	How much	
Job / Local Retailer (601-555-5432)	\$16,000.00 per year	Edit Remove

ADD NEW SOURCE OF INCOME

On average, how many hours per week did Suzanne work in the last month? ⓘ

Does Suzanne have any deductions for 2016?

☐ YES ☒ NO

Yearly income for Suzanne Carson

Based on what you entered, Suzanne's income minus any deductions for 2016 will be about **\$16,000.00**. Is this correct? ⓘ

☐ YES ☒ NO

Current income for Anna Carson

Tell us about any income Anna had in the last month. ⓘ

ADD NEW SOURCE OF INCOME

Does Anna have any deductions for 2016?

☐ YES ☒ NO

Next Step: Income for Anna Carson

Application Process

Job / Local Retailer (601-555-5432) \$16,000.00 per year [Edit](#) [Remove](#)

[ADD NEW SOURCE OF INCOME](#)

On average, how many hours per week did Suzanne work in the last month? [?](#)

Does Suzanne have any deductions for 2016?

[YES](#) [NO](#)

Yearly Income for Suzanne Carson

Based on what you entered, Suzanne's income minus any deductions for 2016 will be about **\$16,000.00**. Is this correct? [?](#)

[YES](#) [NO](#)

Based on what you know today, how much do you think Suzanne will make in 2016?
Tell us what you think your income will be each month. You can come back and update this after you apply.

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
0	\$1,000	0	0	0	0	0	0	0	0	0	0

Total: **\$1,000** this year.

[Cancel](#) [SAVE](#)

Current Income for Anna Carson

Tell us about any income Anna had in the last month. [?](#)

[ADD NEW SOURCE OF INCOME](#)

Does Anna have any deductions for 2016?

Application Process

The screenshot shows the HealthCare.gov website interface. At the top, there's a navigation bar with 'HealthCare.gov' logo, 'Individuals & Families' (selected), and 'Small Businesses'. A user is logged in as 'john' with a 'Log out' link. Below the navigation bar, a progress bar shows 'Apply' (active), 'Get Prequalified', and 'Get Coverage'. The main content area is titled 'Additional questions' with an 'Application ID: 129669646' in the top right. A message states: 'You're almost done. Answering these questions will give you a better chance of getting coverage.' The first question is: 'Do any of these people have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs? (optional)'. It lists three names: John Carson, Suzanne Carson, and Anna Carson, each with an unchecked checkbox. The second question is: 'Do any of these people need help with daily activities (like dressing or using the bathroom), or live in a medical facility or nursing home? (optional)'. It lists the same three names with unchecked checkboxes. The third question is: 'Do any of these people need help paying their medical bills from the last 3 months? (optional)'. It lists the same three names with unchecked checkboxes. At the bottom, there is a large green 'CONTINUE' button.

HealthCare.gov Individuals & Families Small Businesses john Log out

Apply Get Prequalified Get Coverage

Application ID: 129669646

Additional questions

You're almost done. Answering these questions will give you a better chance of getting coverage.

Do any of these people have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs? (optional)

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Do any of these people need help with daily activities (like dressing or using the bathroom), or live in a medical facility or nursing home? (optional)

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Do any of these people need help paying their medical bills from the last 3 months? (optional)

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

CONTINUE

Application Process

John Carson's coverage information

Is John Carson currently enrolled in health coverage? ⓘ

YES

NO

Suzanne Carson's coverage information

Is Suzanne Carson currently enrolled in health coverage? ⓘ

YES

NO

Anna Carson's coverage information

Is Anna Carson currently enrolled in health coverage? ⓘ

YES

NO

Additional coverage questions

Does a child on this application have a parent living outside the home?

YES

NO

Were any of these people found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Questions about life changes

Select anyone in your household who had these changes.

Application Process

John Carson's coverage information

Is John Carson currently enrolled in health coverage? ⓘ

YES NO

What type of coverage does John Carson have? (Select all that apply.)

- ☐ Medicaid ⓘ
- ☐ Children's Health Insurance Program (CHIP) ⓘ
- ☐ Medicare ⓘ
- ☐ TRICARE (Don't check if this person has Direct Care or Line of Duty.) ⓘ
- ☐ VA health care program ⓘ
- ☐ Peace Corps ⓘ
- ☐ Other

Suzanne Carson's coverage information

Is Suzanne Carson currently enrolled in health coverage? ⓘ

YES NO

Anna Carson's coverage information

Is Anna Carson currently enrolled in health coverage? ⓘ

YES NO

Additional coverage questions

Does a child on this application have a parent living outside the home?

YES NO

Application Process

Were any of these people found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Questions about life changes

Select anyone in your household who had these changes.

Did anyone listed below lose health coverage on or after 8/31/2015? ⓘ

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Will anyone listed below lose coverage before 12/29/2015?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Did anyone listed below get married on or after 8/31/2015?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Did anyone listed below get released from incarceration (detention or jail) on or after 8/31/2015?

- ☐ John Carson

Application Process

Select anyone in your household who had these changes.

Did anyone listed below lose health coverage on or after 8/31/2015? ⓘ

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Will anyone listed below lose coverage before 12/29/2015?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Did anyone listed below get married on or after 8/31/2015?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Did anyone listed below get released from incarceration (detention or jail) on or after 8/31/2015?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Did anyone listed below gain eligible immigration status on or after 8/31/2015?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Was anyone listed below adopted, placed for adoption, or placed for foster care on or after 8/31/2015?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Did anyone listed below move on or after 8/31/2015?

- ☐ John Carson
- ☐ Suzanne Carson
- ☐ Anna Carson

Application Process

☐ Anna Carson

Renewal of coverage

To make it easier to determine my eligibility for help paying for coverage in future years, I agree to allow the Marketplace to use my income data, including information from tax returns, for the next 5 years. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time. 



Tax filer attestation

John Carson, did your household file a 2014 tax return and reconcile any premium tax credit you used? 

☐ Yes, 2014 premium tax credits were reconciled.

REVIEW APPLICATION

[Home](#) | [About](#) | [Contact Us](#) | [Privacy](#)

[Help](#) | [FAQ](#) | [Terms of Use](#) | [Privacy Policy](#) | [Accessibility](#) | [Feedback](#)

Application Process

HealthCare.gov Individuals & Families Small Businesses John | Log out

Apply View Account View Coverage

Application summary

Application ID: 129669846

Take a few minutes to review the information you gave us and make changes, if necessary. Once everything is correct, you can sign and submit your application.

Household contact

Full name John Carson
Address 824 Deborah St
Jackson, MS 39208
Phone number 601-555-1234
Email address jcarsontest54@yahoo.com
Get updates by email No
Preferred written language English
Preferred spoken language English

EDIT

Household members

Full name	Date of birth	SSN	Relationship	Sex	Applying for health coverage
John Carson	06/19/1961	XXX-XX-1506	Self	Male	Yes
Suzanne Carson	07/02/1970	XXX-XX-1507	Spouse	Female	Yes
Anna Carson	01/18/2005	XXX-XX-1508	Child	Female	Yes

EDIT

Household income

Name	Type	Amount
John Carson	Job / Local Grocery (601-555-4321)	\$16,000.00 per year

EDIT

Application Process

Basic household questions

[EDIT](#)

Everyone:

- has the same permanent home address and currently lives there.
- is included on the tax return I'll file jointly with my spouse for 2016, and my spouse and I aren't claimed as dependents by anyone else.

No one:

- is currently pregnant or has had a child in the last 60 days.
- is 18-22 and a full-time student.

We're not living with and responsible for a child 18 or younger not on our tax return.

Everyone applying for coverage is a U.S. citizen or U.S. national.

No one applying for coverage:

- is currently incarcerated (detained or jailed).
- is American Indian or Alaska Native.
- is a naturalized or derived citizen.
- listed a name on the application that's different from the one on the Social Security card.
- is eligible for health coverage from their job (including COBRA) or someone else's job, or will be in 2016.
- was in foster care at 18 AND is currently 25 or younger.

Everyone listed as a dependent:

- is 25 or younger.
- is not married.
- will be claimed as a dependent on our federal tax return for 2016.
- is our child.
- is not our stepchild.
- does not live with a different parent who's not on our tax return.

Application Process

Name	Current health coverage	Recently lost health coverage
John Carson	No	No
Suzanne Carson	No	No
Anna Carson	No	No

Agree & confirm

Select "Yes" or "No" for each statement below

- ☒ YES ☐ NO If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent. ⓘ
- ☒ YES ☐ NO I know I must tell the program I'll be enrolled in if information I listed on this application changes. I know I can make changes in my Marketplace account online or by calling 1-800-318-2596. TTY users should call 1-855-889-4325. I know a change in my information could affect eligibility for member(s) of my household. ⓘ

Sign & submit

- ☒ YES ☐ NO I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know I may be subject to penalties under federal law if I intentionally provide false information.

John Carson, type your full name below to sign electronically.

Full name

SUBMIT APPLICATION

Sign Here

Submit Application

Sign & submit

- ☒ YES ☐ NO I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know I may be subject to penalties under federal law if I intentionally provide false information.

John Carson, type your full name below to sign electronically.

John Carson

SUBMITTING APPLICATION...

In Progress

KHBE
Kentucky Health Benefit Exchange

Application Process

The screenshot displays the HealthCare.gov website interface. At the top, the 'HealthCare.gov' logo is on the left, and navigation links for 'Individuals & Families' and 'Small Businesses' are in the center. On the right, there's a user profile for 'john' with a 'Logout' button and an 'Enrolled' status. Below the header, a dark blue navigation bar contains the 'Mississippi' logo, a green 'Apply' button, a blue 'Get Results' button (which is active), and a grey 'Get Coverage' button. A green success message at the top of the main content area states: 'Your application was received and has been processed.' The main heading is 'Eligibility results', followed by a subtext: 'Results based on your application (ID 129669846) submitted on 10/30/2015. Follow these steps below to complete your enrollment. [Learn more about your eligibility results](#)'.

Below this, a white box contains the following information:

We've successfully processed your application.

Step 1: View Your "Coverage Options at a Glance"

This section gives a quick snapshot of your eligibility. It's important to view your full "Eligibility Results" for more detailed information. Continue to Step 2.

Anna Carson	Eligible	For Medicaid
		For Marketplace health plans
		For up to \$653 in premium tax credits for your household
John Carson	Eligible	For lower copayments, coinsurance, and deductibles (cost-sharing reductions) on Silver plans
Suzanne Carson		

Temporary eligibility: You need to provide more information within the next 3 months to keep your coverage. View your "Eligibility Results" to learn how to submit this information.

Step 2: View Your "Eligibility Results"

Application Process

The screenshot displays the Mississippi Health Benefits application interface. At the top, navigation tabs include 'Apply' (active), 'Get Results', and 'Get Coverage'. A user profile for John Carson and Suzanne Carson is shown with a green 'Eligible' status. A red arrow points to a 'Temporary eligibility' warning: 'You need to provide more information within the next 3 months to keep your coverage. View your "Eligibility Results" to learn how to submit this information.' Below this, 'Step 2: View Your "Eligibility Results"' is displayed, followed by a green button labeled 'VIEW ELIGIBILITY RESULTS (PDF)'. A red arrow points to this button with the text 'Click to Open'. 'Step 3: Continue to enrollment' follows, with a grey button labeled 'CONTINUE TO ENROLLMENT'. A red arrow points to this button with the text 'Click to Continue'. At the bottom, a section titled 'Full Medicaid determination' explains that users can still continue with a Medicaid application if they provide information to the Mississippi Health Benefits.

Mississippi

Apply Get Results Get Coverage

HELP

John Carson
Suzanne Carson

Eligible

For lower copayments, coinsurance, and deductibles cost-sharing reductions on Silver plans.

Temporary eligibility: You need to provide more information within the next 3 months to keep your coverage. View your "Eligibility Results" to learn how to submit this information.

Step 2: View Your "Eligibility Results"

Your "Eligibility Results" contain important information about your Marketplace coverage, including your eligibility for coverage, costs, deadlines, and next steps. If you're eligible for coverage through a Marketplace plan, you'll continue to Step 3 to enroll in coverage after you review your results.

VIEW ELIGIBILITY RESULTS (PDF)

Step 3: Continue to enrollment

You've finished and submitted your application, and viewed your "Eligibility Results." Next, you'll choose a plan and enroll in coverage.

CONTINUE TO ENROLLMENT

Full Medicaid determination

It looks like these people aren't eligible for Medicaid. They can still continue with a Medicaid application if we send their information to the Mississippi Health Benefits. Do any of these people want us to send their information to the Mississippi Health Benefits so they can check on Medicaid and The Children's Health Insurance Program (CHIP) eligibility, if applicable?

Alerted to DMI (RFI)

Click to Open

Click to Continue

Eligibility Results

Eligibility Results

At the end of the application, Eligibility results are generated immediately.

If paper application was submitted, a Notice of Eligibility will be mailed to consumer

Family member(s)	Results	Next steps
May Leon	<ul style="list-style-type: none">Eligible for a tax credit (\$449.00 each month, which is \$5,388.00 for the year, for your tax household), but we need more information from you. This calculation is based on the yearly household income of \$30,135.00. This is the amount that you provided on your Marketplace application or the amount that came from the most recent income data sources available.	<ul style="list-style-type: none"><u>Send the Marketplace more information</u>
Jack Leon	<ul style="list-style-type: none"><u>Can choose a health plan with lower copayments, coinsurance, and deductibles (06)</u>Eligible to purchase health coverage through the MarketplaceEligible for a tax credit (\$449.00 each month, which is \$5,388.00 for the year, for your tax household), but we need more information from you. This calculation is based on the yearly household income of \$30,135.00. This is the amount that you provided on your Marketplace application or the amount that came from the most recent income data sources available.	<ul style="list-style-type: none">Choose a health plan and make first month's payment<u>Send the Marketplace more information</u>

Mixed Eligibility

Mixed Eligibility

Eligibility Notice will indicate what program each person on the application is qualified for and indicate any next steps

Jack Leon	<ul style="list-style-type: none">• Can choose a health plan with lower copayments, coinsurance, and deductibles (06)• Eligible to purchase health coverage through the Marketplace• Eligible for a tax credit (\$449.00 each month, which is \$5,388.00 for the year, for your tax household), but we need more information from you. This calculation is based on the yearly household income of \$30,135.00. This is the amount that you provided on your Marketplace application or the amount that came from the most recent income data sources available.	<ul style="list-style-type: none">• <u>Choose a health plan</u> and make first month's payment• Send the Marketplace more information
Tommy Leon	<ul style="list-style-type: none">• May be eligible for Medicaid. This calculation is based on the monthly household income of \$2,511.25 that you provided on your Marketplace application.	<ul style="list-style-type: none">• You will receive a final decision from the [Medicaid agency name]. If you qualify for Medicaid, you won't qualify for a tax credit and lower copayments, coinsurance, and deductibles for Health Insurance Marketplace coverage.

Application Process



Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

John Carson
824 Deborah St
Jackson, MS 39208

Oct 30, 2015

Application Date: October 30, 2015
Application ID: 129669846

Application Process

What should I do next?

Here's what each person in your household needs to do to take the "Next steps" shown in your **Eligibility Results**. If your "Next steps" tell you to send more information, follow instructions for sending it. If you don't, you could lose what you qualify for now because your information doesn't match the data we have, or we can't verify all of the information in your application.

When will Marketplace coverage begin?

If you're eligible to buy a Marketplace plan, your plan's coverage start date depends on the date you select your plan.

What if information from my application changes during the year?

If your circumstances change and the information you gave us when you applied is no longer correct, you need to let us know within 30 days of the change. Changes may affect your eligibility for:

- Premium tax credits
- Enrollment in a plan with lower copayments, coinsurance, and deductibles
- Coverage through [state Medicaid name] or [state CHIP name]

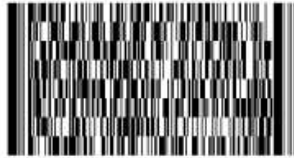
What should I do if I think my Eligibility Results are wrong?

If you have received a final determination and you think we made a mistake, in many cases, you can appeal our decision about your eligibility for health coverage, including Medicaid, CHIP, purchasing health coverage through the Marketplace, a tax credit, cost-sharing reductions, and enrollment periods.

Below is important information to consider when requesting an appeal:

Application Process

Need to send documentation? If your Eligibility Results say that you need to send more information, please also include a copy of this bar code page. This page helps the Marketplace make sure your documents can be easily associated with your application. For more information about choosing documents and uploading or mailing them to the Marketplace, see "8. How to send more information" in "Understanding Your Eligibility Results" included with this notice.



[State].129990294

The Barcode

Application Process

Enroll To-Do List

You're not enrolled yet.

You must complete each step in order to enroll. Work at your own pace. You can come back to complete these tasks later.

Coverage Start Dates

If you confirm your plan(s) between these dates:	Your coverage start date will be:
Nov 1, 2015 – Dec 15, 2015	Jan 1, 2016
Dec 16, 2015 – Jan 15, 2016	Feb 1, 2016
Jan 16, 2016 – Jan 31, 2016	Mar 1, 2016

*To activate your new health coverage, you must pay your first month's premium by your plan's due date. Your plan will contact you in the next few days on how to pay, or you may visit your plan online to make your payment if your plan accepts online payment.

If you received a notice for a hardship exemption that may qualify you for Catastrophic coverage, please report this exemption(s) before you continue. This allows you to shop for Catastrophic health plans for the people who qualify. [Report an exemption](#)

Choosing a Health Plan

Set premium tax credit amount to use for [Learn more](#)

SET TAX CREDIT

Answer household questions [Learn more](#)

ANSWER
QUESTIONS

Select a health plan for Roslyn [Learn more](#)

CHOOSE A PLAN



Application Process

Updated Enroll To-Do List

Choosing a Health Plan

- ✓ Premium tax credit amount is set for **Suzanne and John** [CHANGE TAX CREDIT](#)
- ✓ Household questions answered [CHANGE ANSWERS](#)
- Select a health plan for **Suzanne and John** [Learn more](#) [CHOOSE A PLAN](#)
- Decide about a dental plan (optional) [Learn more](#) [DECIDE ON DENTAL](#)
- Confirm your plan choices and enroll [Learn more](#) [FINAL REVIEW](#)

Note how once item is complete the button changes to blue.

86 plans available

SORT BY

Premium

PLAN TYPE

Health plans

FILTERS

Monthly premium

less than \$200 (1)

less than \$300 (35)

less than \$400 (83)

less than \$500 (86)

Plan category

Bronze plans (29)

Silver plans (39)

Gold plans (18)

Plan type

PPO (24)

HMO (49)

POS (13)

Medical management programs

Asthma (64)

Heart Disease (86)

Depression (58)

Diabetes (88)

High Blood Pressure and High Cholesterol (81)

Low Back Pain (45)

Ambetter from Buckeye Health · Ambetter Essential Care 1 (2016)

Bronze HMO | Plan ID: 41047OH0010017

Estimated monthly premium

\$196

Deductible ⓘ

\$6,800

Estimated Individual Total

Out-of-pocket maximum ⓘ

\$6,800

Estimated Individual Total

Estimated total yearly costs

Total premiums for the year \$2,347

Deductible, copayments, and other costs \$1,490

Total **\$3,837**

EDIT

Understand this ⓘ

Your doctors, medical facilities, and prescription drugs

EDIT

BETA ⓘ

Copayments / Coinsurance ⓘ

Emergency room care: No Charge After Deductible

Generic drugs: \$20

Primary doctor: No Charge After Deductible

Specialist doctor: No Charge After Deductible

LEARN MORE ABOUT THIS PLAN

COMPARE

CareSource · CareSource Just4Me Bronze

Apply by Phone

Application Process

1-800-318-2596

The FFM Call Center is open 7 days per week, 24 hours per day
(closed Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas)

When a consumer applies by phone, a customer service representative will fill out the application with the information the consumer is giving during the call.

They will then read the eligibility results to the consumer and explain those results.

The customer service rep will then tell the consumers the plans that are available with details about premium payment, deductibles, etc. The CSR is in plan compare and verbally reviewing the information with the consumer.

TTY 1-855-889-4325

Application Process

Verbal Authorization

You can call the FFM Call Center **with** a consumer for assistance in applying or enrolling or assisting with other issues.

Consumers can call the Marketplace Call Center with his/her third party representative and give **verbal authorization** for the third party representative to speak on their behalf.

This authorization can last for up to one year unless the consumer calls back to remove the authorization.

Call center purposes only

Must call with the consumer

Lasts up to one Year

Allows Assistants to facilitate
communication not act

Application Process

Non English speaking consumers can get assistance through the Health Insurance Marketplace Call Center. They will be connected to an interpretation service to assist through the application and enrollment process.

Getting Help in a Language Other than English

- Interpreter services in more than 240 languages are available at no cost at 1-800-318-2596
 - CMS Product No. 11658 translates the message above in
 - Albanian, Amharic, Arabic, Bengali, Cantonese, Chinese, French, French Creole, German, Gujarati, Hindi, Korean, Mandarin, Punjabi, Pennsylvania Dutch, Persian, Polish, Portuguese, Romanian, Russian, Spanish, Tagalog, Thai, Urdu, and Vietnamese

Application Process

The FFM Call Center can be used for any need

Information

Pre-Screening

Applying

Enrolling

Reporting Changes

Reporting problems or issues

Password reset

SEPs

Apply by Mail

Application Process

Paper Applications

Paper Applications can be filled out and mailed.

Eligibility Results are mailed to applicant within two weeks

Consumers can then either create an online account or call the call center to complete their enrollment.

The paper application for 2017 coverage will be available November 1, 2016.

Paper application can be printed from the HealthCare.gov website.

Application Process

 **Application for Health Coverage & Help Paying Costs**  09/2015
Form Approved
OMB No. 0938-1191

 Apply faster online	Apply faster online at HealthCare.gov .
 Use this application to see what coverage you qualify for	<ul style="list-style-type: none">Affordable private health insurance plans that offer comprehensive coverage to help you stay well.A new tax credit that can immediately help pay your premiums for health coverage.Free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You may qualify for a free or low-cost program, even if you earn as much as \$95,400 a year (for a family of 4).
 Who can use this application?	<ul style="list-style-type: none">Use this application to apply for anyone in your family.Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.If you're single, you may be able to use a short form. Visit HealthCare.gov.Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.If someone is helping you fill out this application, you may need to complete Appendix C.
 What you may need to apply	<ul style="list-style-type: none">Social Security Numbers (or document numbers for any eligible immigrants who need coverage).Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements).Policy numbers for any current health insurance.Information about any job-related health insurance available to your family.
 Why do we ask for this information?	We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, visit HealthCare.gov or see instructions.
 What happens next?	Send your complete, signed application to the address on page 7. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow up with you within 1-2 weeks, and you may receive a call from the Marketplace if we need more information. You'll get an eligibility determination letter in the mail after your application is processed. If you don't hear from us, contact the Marketplace Call Center. Filling out this application doesn't mean you have to buy health coverage.
 Get help with this application	<ul style="list-style-type: none">Online: HealthCare.gov.Phone: Call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.In person: There may be counselors in your area who can help. Visit HealthCare.gov, or call the Marketplace Call Center at 1-800-318-2596 for more information.En Español: Llame a nuestro centro de ayuda gratis al 1-800-318-2596.Other languages: If you need help in a language other than English, call 1-800-318-2596 and tell the customer service representative the language you need. We'll get you help at no cost to you.

PIA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: OMB, 7500 Security Boulevard, Attn: PIA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Delays

Must wait for FFM to enter

Questions may not be answered completely

Will involve follow up

Application Process



Page 1 of 7

Please print in capital letters using black or dark blue ink only.
Fill in the circles (○) like this → ●.

STEP 1: Tell us about yourself

(We need one adult in the family to be the contact person for your application)

1. First name		Middle name		Last name		Suffix	
2. Home address (Leave blank if you don't have one.)						3. Apartment or suite number	
4. City		5. State	6. ZIP code		7. County, parish, or township		
		<div></div>	<div></div>				
8. Mailing address (if different from home address)						9. Apartment or suite number	
10. City		11. State	12. ZIP code		13. County, parish, or township		
		<div></div>	<div></div>				
14. Daytime phone number				15. Evening phone number			
(<div></div>) <div></div> - <div></div>				(<div></div>) <div></div> - <div></div>			
16. Do you want to get information about this application by email? <input type="radio"/> Yes <input type="radio"/> No							
Email address: <div></div>							
17. What's your preferred spoken language? What's your preferred written language?							

Application Process

STEP 2: Tell us about your family.

Who do you need to include on this application?

Complete the Step 2 pages for every person in your family and household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

For adults who need coverage:

Include these people even if they aren't applying for health coverage themselves:

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return). You don't need to file taxes to get health coverage.

For children under age 21 who need coverage:

Include these people even if they aren't applying for health coverage themselves:

- Any parent (or stepparent) they live with
 - Any sibling they live with
 - Any son or daughter they live with, including stepchildren
 - Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.
-

Complete Step 2 for each person in your family.

Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

Application Process

STEP 2: PERSON 1 (Start with yourself.)



Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name		Middle name	Last name	Suffix
<input type="text"/>				
2. Relationship to PERSON 1? SELF	3. Are you married? <input type="radio"/> Yes <input type="radio"/> No	4. Date of birth (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>		5. Sex <input type="radio"/> Male <input type="radio"/> Female
6. Social Security Number (SSN) <input type="text"/> - <input type="text"/> - <input type="text"/>				
<p>★ We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. If you need help getting an SSN, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>				
7. Do you plan to file a federal income tax return NEXT YEAR? You can still apply for coverage even if you don't file a federal income tax return. <input type="radio"/> YES. If yes, please answer questions a-c. <input type="radio"/> NO. If no, skip to question c.				
a. Will you file jointly with a spouse? <input type="radio"/> Yes <input type="radio"/> No If yes, write name of spouse: <input type="text"/>				
b. Will you claim any dependents on your tax return? <input type="radio"/> Yes <input type="radio"/> No If yes, list name(s) of dependents: <input type="text"/>				
c. Will you be claimed as a dependent on someone's tax return? <input type="radio"/> Yes <input type="radio"/> No If yes, please list the name of the tax filer: <input type="text"/> How are you related to the tax filer? <input type="text"/>				
8. Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No a. If yes, how many babies are expected during this pregnancy? <input type="text"/>				
9. Do you need health coverage? Even if you have coverage, there might be a program with better coverage or lower costs. <input type="radio"/> YES. If yes, answer all the questions below. <input type="radio"/> NO. If no, SKIP to the income questions on page 3. Leave the rest of this page blank.				
10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? <input type="radio"/> Yes <input type="radio"/> No				

Application Process

11. Are you a U.S. citizen or U.S. national ? <input type="radio"/> Yes <input type="radio"/> No	
12. Are you a naturalized or derived citizen ? (This usually means you were born outside the U.S.) <input type="radio"/> YES. If yes , complete a and b. <input type="radio"/> NO. If no , continue to question 13.	
a. Alien number: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div>	b. Certificate number: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div>
After you complete a and b, SKIP to question 14.	
13. If you aren't a U.S. citizen or U.S. national , do you have eligible immigration status? <input type="radio"/> YES . Enter document type and ID number. See instructions.	
Immigration document type <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div>	Status type (optional) <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div>
Write your name as it appears on your immigration document. <div style="border: 1px solid black; width: 200px; height: 20px; margin: 2px;"></div>	
Alien or I-94 number <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div>	Card number or passport number <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div>
SEVIS ID or expiration date (optional) <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div>	Other (category code or country of issuance) <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"></div>
a. Have you lived in the U.S. since 1996? <input type="radio"/> Yes <input type="radio"/> No	
b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? <input type="radio"/> Yes <input type="radio"/> No	
14. Do you want help paying for medical bills from the last 3 months? <input type="radio"/> Yes <input type="radio"/> No	
15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? (Select "yes" if you or your spouse takes care of this child.) <input type="radio"/> Yes <input type="radio"/> No	
16. Tell us the names and relationships of any children under 19 that live with you in your household: <div style="border: 1px solid black; width: 200px; height: 20px; margin: 2px;"></div>	
17. Are you a full-time student? <input type="radio"/> Yes <input type="radio"/> No	
18. Were you in foster care at age 18 or older? <input type="radio"/> Yes <input type="radio"/> No	
Optional: (Fill in all that apply.)	19. If Hispanic/Latino, ethnicity : <input type="radio"/> Mexican <input type="radio"/> Mexican American <input type="radio"/> Chicano/a <input type="radio"/> Puerto Rican <input type="radio"/> Cuban <input type="radio"/> Other _____
	20. Race : <input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Filipino <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Asian Indian <input type="radio"/> Chinese <input type="radio"/> Vietnamese <input type="radio"/> Other Asian <input type="radio"/> Native Hawaiian <input type="radio"/> Guamanian or Chamorro <input type="radio"/> Samoan <input type="radio"/> Other Pacific Islander <input type="radio"/> Other _____

Application Process

STEP 2: PERSON 1 (Continue with yourself.)



Current job & income information

☐ **Employed:** If you're currently employed, tell us about your income. Start with question 21.

☐ **Not employed:** Skip to question 31.

☐ **Self-employed:** Skip to question 30.

Current job 1:

21. Employer name

a. Employer address

b. City

c. State

d. ZIP code

22. Employer phone number

() -

23. Wages/tips (before taxes)

\$

☐ Hourly

☐ Weekly

☐ Every 2 weeks

☐ Twice a month

☐ Monthly

☐ Yearly

24. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper.)

25. Employer name

a. Employer address

b. City

c. State

d. ZIP code

26. Employer phone number

() -

27. Wages/tips (before taxes)

\$

☐ Hourly

☐ Weekly

☐ Every 2 weeks

☐ Twice a month

☐ Monthly

☐ Yearly

28. Average hours worked each WEEK

29. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

30. If self-employed, answer a and b:

Application Process

31. **Other income you get this month:** Fill in all that apply, and give the amount and how often you get it. Fill in here if none. ☐

NOTE: You **don't** need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).

<input type="radio"/> Unemployment	\$		How often?		<input type="radio"/> Alimony received	\$		How often?	
<input type="radio"/> Pension	\$		How often?		<input type="radio"/> Net farming/fishing	\$		How often?	
<input type="radio"/> Social Security	\$		How often?		<input type="radio"/> Net rental/royalty	\$		How often?	
<input type="radio"/> Retirement accounts	\$		How often?		<input type="radio"/> Other income	\$		How often?	
					Type:				

32. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 30b).

<input type="radio"/> Alimony paid	\$		How often?		<input type="radio"/> Other deductions	\$		How often?	
<input type="radio"/> Student loan interest	\$		How often?		Type:				

33. **Complete this question if your income changes during the year,** like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person. ➡

Your total income this year	Your total income next year (if you think it will be different)
\$	\$

Thanks! This is all we need to know about you.

KHBE
Kentucky Health Benefit Exchange

Application Process

STEP 2: PERSON 2

Note: If this person doesn't need health coverage, just answer questions 1-11 on this page. Make a copy of pages 4-5 if there are more than 2 people in your household.



Page 4 of 7

Complete this page for your spouse/partner and child(ren) who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

1. First name		Middle name	Last name	Suffix
2. Relationship to PERSON 1? <i>See instructions.</i>		3. Is PERSON 2 married? <input type="radio"/> Yes <input type="radio"/> No		4. Date of birth (mm/dd/yyyy) []/[]/[]
5. Sex <input type="radio"/> Male <input type="radio"/> Female		6. Social Security Number (SSN) []-[]-[]		
★ We need this if you want health coverage for PERSON 2, and PERSON 2 has an SSN.				
7. Does PERSON 2 live at the same address as PERSON 1? <input type="radio"/> Yes <input type="radio"/> No If no, list address:				
8. Does PERSON 2 plan to file a federal income tax return NEXT YEAR? (You can still apply for coverage even if PERSON 2 doesn't file a federal income tax return.) <input type="radio"/> YES. If yes, please answer questions a-c. <input type="radio"/> NO. If no, skip to question c.				
a. Will PERSON 2 file jointly with a spouse? <input type="radio"/> Yes <input type="radio"/> No If yes, write name of spouse:				
b. Will PERSON 2 claim any dependents on his or her tax return? <input type="radio"/> Yes <input type="radio"/> No If yes, list name(s) of dependents:				
c. Will PERSON 2 be claimed as a dependent on someone's tax return? <input type="radio"/> Yes <input type="radio"/> No If yes, please list the name of the tax filer: How is PERSON 2 related to the tax filer?				
9. Is PERSON 2 pregnant? <input type="radio"/> Yes <input type="radio"/> No a. If yes, how many babies are expected during this pregnancy? []				
10. Does PERSON 2 need health coverage? (Even if PERSON 2 has coverage, there might be a program with better coverage or lower costs.) <input type="radio"/> YES. If yes, answer all the questions below. <input type="radio"/> NO. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.				
11. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? <input type="radio"/> Yes <input type="radio"/> No				
12. Is PERSON 2 a U.S. citizen or U.S. national? <input type="radio"/> Yes <input type="radio"/> No				

Application Process

		SKIP to question 15.	
14. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status? <input type="radio"/> YES. Enter document type and ID number. See instructions.			
Immigration document type:	Status type (optional):	Write PERSON 2's name as it appears on their immigration document.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Alien or I-94 number		Card number or passport number	
<input type="text"/>		<input type="text"/>	
SEVIS ID or expiration date (optional)		Other (category code or country of issuance)	
<input type="text"/>		<input type="text"/>	
a. Has PERSON 2 lived in the U.S. since 1996?		<input type="radio"/> Yes <input type="radio"/> No	
b. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military?		<input type="radio"/> Yes <input type="radio"/> No	
15. Does PERSON 2 want help paying for medical bills from the last 3 months?		<input type="radio"/> Yes <input type="radio"/> No	
16. Does PERSON 2 live with at least one child under the age of 19, and is PERSON 2 the main person taking care of this child? (Select "yes" if PERSON 2 or their spouse takes care of this child.)		<input type="radio"/> Yes <input type="radio"/> No	
17. Tell us the names and relationships of any children under 19 that live with PERSON 2 in their household: (These can be the same children listed on page 2.)			
<input type="text"/>			
18. Was PERSON 2 in foster care at age 18 or older?		<input type="radio"/> Yes <input type="radio"/> No	
Please answer these questions if PERSON 2 is 22 or younger:			
19. Did PERSON 2 have insurance through a job and lose it within the past 3 months?		<input type="radio"/> Yes <input type="radio"/> No	
a. If yes, end date:	<input type="text"/> / <input type="text"/> / <input type="text"/>	b. Reason the insurance ended: <input type="text"/>	
20. Is PERSON 2 a full-time student?		<input type="radio"/> Yes <input type="radio"/> No	
Optional: (Fill in all that apply.)	21. If Hispanic/Latino, ethnicity: <input type="radio"/> Mexican <input type="radio"/> Mexican American <input type="radio"/> Chicano/a <input type="radio"/> Puerto Rican <input type="radio"/> Cuban <input type="radio"/> Other _____		
	22. Race: <input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Filipino <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Asian Indian <input type="radio"/> Chinese <input type="radio"/> Vietnamese <input type="radio"/> Other Asian <input type="radio"/> Native Hawaiian <input type="radio"/> Guamanian or Chamorro <input type="radio"/> Samoan <input type="radio"/> Other Pacific Islander <input type="radio"/> Other _____		
NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov , or call us at 1-800-318-2596. Para obtener una copia de este formulario en Español, llame 1-800-318-2596. If you need help in a language other than English, call 1-800-318-2596 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-855-889-4325.			

Application Process

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STEP 3: American Indian or Alaska Native (AI/AN) family member(s)



1. Are you or is anyone in your family American Indian or Alaska Native?

☐ NO. If no, continue to Step 4. ☐ YES. If yes, continue to Step 4, plus complete Appendix B and include with application.

STEP 4: Your family's health coverage

1. For every year that you got a premium tax credit, did your household file a tax return and reconcile any premium tax credit you used?

☐ YES, premium tax credits were reconciled. Fill in the circle only if ALL of these apply to you:

- You used advance payments of premium tax credits (APTC) in one or more past years to help lower your costs for Marketplace coverage.
- The tax filer for your household filed a federal income tax return for each of these years.
- The tax return filed compared the amount of APTC used to the rest of the tax return information for each year.

2. Was anyone on this application found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days? (Select yes only if someone was found not eligible for this coverage by your state, not by the Marketplace.) ☐ Yes ☐ No

Who?

Or, was anyone on this application found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013? ☐ Yes ☐ No

Who?

3. Did anyone on this application apply for coverage during the Marketplace open enrollment period? ☐ Yes ☐ No

Who?

4. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, like a parent or spouse, even if they don't accept the coverage.

☐ YES. Continue and then complete Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO.

5. Is anyone enrolled in health coverage now?

☐ YES. If yes, continue to question 6. ☐ NO. If no, SKIP to Step 5.

6. Information about current health coverage. (Make a copy of this page if more than 2 people have health coverage now.)

Write the type of coverage, like employer insurance, COBRA, Medicaid, CHIP, Medicare, TRICARE, VA health care program, Peace Corps, or other. (Don't tell us about TRICARE if you have Direct Care or Line of Duty.)

Name of person enrolled in health coverage

Type of coverage:

Application Process

6. Information about current health coverage. *(Make a copy of this page if more than 2 people have health coverage now.)*

Write the type of coverage, like employer insurance, COBRA, Medicaid, CHIP, Medicare, TRICARE, VA health care program, Peace Corps, or other.
(Don't tell us about TRICARE if you have Direct Care or Line of Duty.)

PERSON 1:

Name of person enrolled in health coverage

Type of coverage:

☐ Employer insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)*

Name of health insurance company

Policy/ID number

If it's another kind of coverage:

Name of health insurance company

Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ☐ Yes ☐ No

PERSON 2:

Name of person enrolled in health coverage

Type of coverage:

☐ Employer insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)*

Name of health insurance company

Policy/ID number

If it's another kind of coverage:

Name of health insurance company

Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ☐ Yes ☐ No

Application Process

STEP 5: Your agreement & signature



1. Do you agree to allow the Marketplace to use income data, including information from tax returns, for the next 5 years? ☐ Yes ☐ No

To make it easier to determine your eligibility for help paying for coverage in future years, you can agree to allow the Marketplace to use updated income data, including information from tax returns. The Marketplace will send a notice and let you make any changes. The Marketplace will check to make sure you're still eligible, and may have to ask you to prove that your income still qualifies. You can opt out at any time.

If no, automatically update my information for the next:

☐ 4 years ☐ 2 years ☐ Don't use my tax data to renew my eligibility for help paying for health coverage
☐ 3 years ☐ 1 year (selecting this option may impact your ability to get help paying for coverage at renewal.)

2. Is anyone applying for health insurance on this application incarcerated (detained or jailed)? ☐ Yes ☐ No

If yes, tell us the person's name. The name of the incarcerated person is:

☐ Fill in here if this person is facing disposition of charges.

If anyone on this application is eligible for Medicaid:

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit [HealthCare.gov](https://www.healthcare.gov) or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Application Process

What should I do if I think my eligibility results are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your Marketplace eligibility results, visit [HealthCare.gov/marketplace-appeals/](https://www.healthcare.gov/marketplace-appeals/). Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001. You can appeal eligibility for purchasing health coverage through the Marketplace, enrollment periods, tax credits, cost-sharing reductions, Medicaid, and CHIP, if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you're eligible for. Depending on your state, you may be able to appeal through the Marketplace or you may have to request an appeal with the state Medicaid or CHIP agency.

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C.

Signature	Date signed (mm/dd/yyyy)										
<div>→</div>	<table border="1"><tr><td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></td></tr></table>			/			/				
		/			/						

If you're signing this application outside of Open Enrollment (between November 1 and January 30), make sure you review Appendix D ("Questions about life changes").

STEP 6: Mail completed application



Mail your signed application to:
Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001



If you want to register to vote, you can complete a voter registration form at www.eac.gov.



NEED HELP WITH YOUR APPLICATION? Visit [HealthCare.gov](https://www.healthcare.gov), or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

Application Process

Appendix A



Form Approved
OMB No. 0938-1191

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Make a copy of this page and take it to the employer who offers coverage to help you answer these questions.

EMPLOYEE INFORMATION

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

EMPLOYER INFORMATION

3. Employer name	4. Employer Identification Number (EIN)	
<input type="text"/>	<input type="text"/> - <input type="text"/>	
5. Employer address	6. Employer phone number	
<input type="text"/>	(<input type="text"/>) <input type="text"/> - <input type="text"/>	
7. City	8. State	9. ZIP code
<input type="text"/>	<input type="text"/>	<input type="text"/>
10. Who can we contact about employee health coverage at this job?		
<input type="text"/>		
11. Phone number (if different from above)	12. Email address	
(<input type="text"/>) <input type="text"/> - <input type="text"/>	<input type="text"/>	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

☐ YES (Continue)

☐ NO (Stop here, and return to Step 5 in the application.)

a. If you're in a waiting or probationary period,
when can you enroll in coverage? (mm/dd/yyyy)

Application Process

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

☐ YES (Continue) ☐ NO (Stop here, and return to Step 5 in the application.)

a. If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy)

/ /

List the names of anyone else who is eligible for coverage from this job.

Name	Name	Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

☐ NO (Stop here, and return to Step 5 in the application.)

Name	Name	Name

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly (Go to next question.)

16. What change, if any, will the employer make for the new plan year?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change: (mm/dd/yyyy) / /

.. ☐ Yes ☐ No

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly (Go to next question.)

16. What change, if any, will the employer make for the new plan year?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change: (mm/dd/yyyy) / /

(Go to next question.)

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change: (mm/dd/yyyy) / /

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change: (mm/dd/yyyy) / /

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change: (mm/dd/yyyy) / /

☐ Yearly

* A health plan meets the minimum value standard if pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. In other words, in most cases a plan that meets minimum value will cover 60% of covered medical costs. You'd pay 40%. Most job-based plans meet the minimum value standard.

Application Process

Appendix B



Form Approved
OMB No. 0938-1191

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native and are applying for coverage. Submit this with your "Application for Health Coverage & Help Paying Costs."

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the questions below to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1:	1. Name (First name, Middle name, Last name)	
	<input type="text"/>	
	2. Member of a federally recognized tribe? <input type="radio"/> Yes <input type="radio"/> No	
	If yes, Tribe name:	State tribe is located in: <input type="text"/>
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?..... <input type="radio"/> Yes <input type="radio"/> No		
	If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?..... <input type="radio"/> Yes <input type="radio"/> No	
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:		
	<ul style="list-style-type: none">• Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties• Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)• Money from selling things that have cultural significance	
	How often?	
\$	<input type="text"/>	<input type="text"/>

Application Process

Appendix C



Form Approved
OMB No. 0938-1191

Assistance with completing this application

For certified application counselors, navigators, agents, and brokers only

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

		/			/				
--	--	---	--	--	---	--	--	--	--

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

5. Agents/Brokers only: NPN number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

Application Process

Appendix D



Form Approved
OMB No. 0938-1191

Questions about life changes

(You must complete the rest of this application along with this page. Don't submit this page by itself.)

If anyone on this application experienced certain life changes in the past 60 days, fill out the following questions. Certain life changes allow your coverage through the Marketplace to start right away. We also recommend you answer these questions if you're applying after the annual Open Enrollment Period ends and before the next annual Open Enrollment Period starts.

These questions are optional. If your life circumstances haven't changed, you can leave the answers blank. You can enroll in Medicaid and the Children's Health Insurance Program (CHIP) any time of the year, even if you didn't experience life changes. Members of federally recognized tribes and Alaska Native shareholders can enroll in coverage through the Marketplace any time of the year.

Tell us about changes in your household.

1. Someone lost health coverage in the last 60 days, or expects to lose coverage in the next 60 days.

Names	Date coverage ended or will end (mm/dd/yyyy)																				
<input type="checkbox"/> Check here if coverage ended because not paying premiums.	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2">/</td><td colspan="2">/</td><td colspan="6"></td></tr></table>											/		/							
/		/																			

2. Someone got married in the last 60 days.

Names	Date (mm/dd/yyyy)																				
	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2">/</td><td colspan="2">/</td><td colspan="6"></td></tr></table>											/		/							
/		/																			

3. Someone was released from incarceration, detention, or jail in the last 60 days.

Names	Date (mm/dd/yyyy)																				
	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2">/</td><td colspan="2">/</td><td colspan="6"></td></tr></table>											/		/							
/		/																			

4. Someone gained eligible immigration status in the last 60 days.

Names	Date (mm/dd/yyyy)																				
	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2">/</td><td colspan="2">/</td><td colspan="6"></td></tr></table>											/		/							
/		/																			

Application Process

Federal Call center will enter the paper application upon receipt.

Eligibility Results are mailed to the consumer within 2 weeks

If the application is not complete, the FFM will call the consumer to gather missing information.

Eligibility results will have an application number. Consumer should keep this for their records.

Once the consumer has received their Eligibility Determination, they can either create an online account or call the call center to continue with enrollment.

Application Process

Online

Quick

Dynamic application that gathers all necessary information

Complete process at one time

Must create an online account
Must pass ID Proofing before moving forward

Paper

Can complete several in a single event

Can send copies of ID information with application

Delays

Must wait for FFM to enter

Questions may not be answered completely

Will involve follow up

Call Center

Quick

All info is entered

Complete process at one time

Cannot see the screen when they are reviewing available plans
Wait times during OEP

Thank you